COVENTRY HEALTH CARE
OF NEBRASKA, INC.
HMO POINT OF SERVICE
OPEN ACCESS
EVIDENCE OF COVERAGE

Welcome to Coventry Health Care of Nebraska!

We are extremely pleased to have you enrolling in our health plan and look forward to serving you. We have built a strong network of area physicians, hospitals, and other providers to offer a broad range of services for your medical needs.

As a Coventry Health Care of Nebraska member, it is important that you understand the way your health plan operates. This Evidence of Coverage contains the information you need to know about your coverage with us.

Please take a few minutes to read these materials and to make your covered family members aware of the provisions of your coverage. Our Customer Service Department is available to answer any questions you may have about your coverage. You can reach them at (800) 288-3343 Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time.

We look forward to serving you and your family.

Sincerely,

President and Chief Executive Officer

Coventry Health Care of Nebraska, Inc.

Evidence of Coverage

The Agreement between Coventry Health Care of Nebraska, Inc. (hereafter called "Health Plan", "We", "Us", or "Our") and you the Subscriber is made up of:
This Evidence of Coverage, and amendments;
The Enrollment Form
Applicable Riders; and
The Group Master Contract

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to the Agreement unless approved in writing by an officer of the Health Plan, and the resulting waiver, change, or amendment is attached to the Agreement. The Agreement begins on the date defined in the Group Master Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in the Agreement and to all the rules and regulations of the Health Plan. By paying premiums or having premiums paid on Your behalf, You accept the provisions of the Agreement.

THIS AGREEMENT HAS AN OUT-OF-NETWORK OPTION WHICH GIVES YOU THE OPPORTUNITY TO SEEK CARE FROM NON-PARTICIPATING PROVIDERS. UTILIZING THE OUT-OF-NETWORK OPTION WILL INCREASE THE AMOUNT YOU PAY FOR THE CARE YOU RECEIVE. PLEASE READ THE PROVISION ENTITLED "REFERRALS AND AUTHORIZATIONS" WHICH APPEARS AS SECTION 1.2 BELOW, AND CALL OUR CUSTOMER SERVICE DEPARTMENT WITH QUESTIONS.

THIS EVIDENCE OF COVERAGE SHOULD BE READ AND RE-READ IN ITS ENTIRETY. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Evidence of Coverage have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, the Agreement may be amended. When that occurs, We will provide an Amendment or new Evidence of Coverage to You. You should keep this document in a safe place for Your future reference.

Coventry Health Care of Nebraska
P.O. Box 541210
Omaha, NE 68154-9210
(800) 288-3343

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SECTION 1
USING YOUR BENEFITS

1.1 Membership Identification (ID) Card

Every Health Plan Member receives a membership ID card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive health care services. If Your Health Plan ID card is missing lost, or stolen, contact the Health Plan Customer Service Department at (800) 288-3343; or You may request an ID card by utilizing our website at www.CHCNebraska.com.

1.2 Referrals and Authorizations

Members may receive Medically Necessary care from Participating Providers or may receive Medically Necessary care from Providers who are not affiliated with Us in any way. Such services may be delivered in or out of the Service Area. In the event You require hospitalization, all care must be obtained from a Participating Provider unless specifically authorized by Us. If Your Participating Provider feels that You need to see a Physician or other medical Provider who does not participate with the Health Plan, then Your Participating Provider must call or submit, in writing, medical information to Us. The Health Plan's medical staff will review the information and will notify You and Your Participating Provider of the coverage decision.

Out-of-Network Coverage Option

You may receive Covered Services from Non-Participating Providers. If you self-refer to a Non-Participating Provider, You are responsible for ensuring that the Non-Participating Provider complies with Our Utilization Management Policies. You must in certain situations receive Pre-Authorization from Us prior to receiving a Covered Service (check Your Schedule of Benefits or call Our Customer Service Department to determine when Covered Services require Pre-Authorization). Under the Out-of-Network Option, the Covered Services may be delivered in or out of the Service Area.

Except for Emergency Services, coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Copayments, Coinsurance and Deductibles. The Out-of-Network Rate is equivalent to the current Medicare fee schedule or diagnosis group rate, as applicable, for the services and supplies rendered, taking into account the appropriate Medicare geographic adjustments. If there is no corresponding Medicare rate for the particular service, the Plan shall pay the amount that the Plan would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with Us.

If the amount You are charged for a service is equal to or less than the Out-of-

Network Rate, the charges should be completely Covered by Your Out of Network Benefit, except for any Copayment, Deductible and Coinsurance payments You must make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular service, you must pay the excess. For example, assume Your Coinsurance is 20%, the doctor's bill is $150 and the Out-of-Network Rate is $100. In this example, We would pay $80, You would pay Coinsurance of $20 plus the $50 in actual charges that exceeds the Out-of Network Rate. Payments for charges in excess of the Out-of-Network Rate do not count towards your annual Out-of-Pocket Maximum.

1.3 Utilization Management Program

Our Utilization Management Program is designed to assure that You receive Medically Necessary health care in a timely manner, and at the most reasonable cost. Our Utilization Management Program nurses review requests for non-emergency and non-maternity admissions and outpatient surgeries and procedures. In addition, the utilization management nurses monitor the care provided during a Hospital stay and in the home after discharge. The Utilization Management Program is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

When you receive care from a Provider, please comply with all of the policies and procedures of the Utilization Management Program. Generally, the policies are:

(a) Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding the treatment of You or Your Dependent.

(b) If You or Your dependent request services to be provided beyond the level of care authorized by Us having full knowledge that such services were not authorized for payment by Us, then a financial penalty as stated in the Schedule of Benefits will be deducted from any Benefits payable for the claim from a non-Preferred Provider. The Provider may bill You directly for any financial penalty which he received for providing services You requested at the non-authorized level of care.

(c) If You request services which are not Medically Necessary having full knowledge that such services were not authorized for payment, then You will be responsible for all charges for services incurred and not authorized.

(d) If You are admitted to a facility prior to the date authorized by Us, unless it is an emergency admission, then You will be responsible for all charges related to the unauthorized days.

(e) If We authorize an admission, outpatient surgery or procedure based on a material misrepresentation about the Covered Person's health condition that was knowingly made by the Covered Individual or the provider of the service, supply, or

other item., and the authorized services are not Medically Necessary and a Covered Service, payment will be denied for charges incurred for those services.

(f) Failure to notify Us within the designated time frame will not adversely affect Coverage of emergency services.

(g) If You require organ transplant services or complex surgical procedures, You may be admitted to a Hospital that has been designated an approved facility for transplants or complex surgical procedures, as We deem appropriate.

(h) You have the right to appeal any Utilization Management Program payment decision according to Our Grievance and Appeal Procedures.

1.4 Copayments, Coinsurance, and Deductibles

You are responsible for paying Copayments to Participating Providers and Non-Participating Providers at the time of service. Coinsurance amounts, based on the Health Plan's reimbursement to the Provider, will be billed to You at a later time by the Provider. Specific Copayments, Coinsurance, and Deductible amounts are listed in the Schedule of Benefits.

Individual Deductible. A Member must satisfy the individual Deductible amount in each Calendar year before coverage for Covered Services are payable for the Member. The Member is responsible for direct payment of the individual Deductible amount to the Provider.

Family Deductible. Coverage for Covered Services are payable for all Members in a family without additional Deductibles during the remainder of a Calendar year upon the earliest of: (1) the date three Members in a family have each satisfied the individual Deductible; or (2) the date family members have cumulatively satisfied an amount equal to three individual Deductibles. However, should there be less than three Members in a family, each Member must meet one hundred percent (100%) of the individual Deductible.

Carryover. Deductible amounts paid by the Member during the last three (3) months of the calendar year shall be applied toward satisfaction of the Member's Individual Deductible for the next calendar year.

Prior Carrier Deductible Credit. With regard to groups that have been effective with Us for less than one year; if a Member failed to satisfy his or her Individual Deductible under the prior carrier's coverage, any eligible charges incurred by the Member during the last three (3) months of coverage with the prior carrier shall be applied toward satisfaction of the Member's Individual Deductible for the remainder of the calendar year in which the group first becomes effective with Us.

In order to receive this benefit, Members must mail their Explanations of Benefits to our Customer Service Department with a written statement that the Member wishes

the Deductible amounts paid by the Member to be carried over into the current calendar year. Our Customer Service Department must receive the Explanation of Benefits if the Member wishes to carry over the Deductible amounts within sixty (60) days of Enrollment for new groups.

1.5 Out-of-Pocket Maximum

The individual Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for Covered Services in a calendar year. The family Out-of-Pocket Maximum is the limit on the total amount Members of the same family covered under the Agreement must pay for Covered Services in a calendar year. Copayments do not apply to the Out-of-Pocket Maximum. Members must continue to pay Copayments even after the Out-of-Pocket Maximum is met.

With respect to the Out-of-Network Coverage option, even if You have reached the Out-of-Pocket Maximum, a Non-Participating Provider may require You to pay amounts in excess of the Out-of-Network Rate. Furthermore, amounts above the Out-of-Network Rate related to Non-Participating Providers which You pay, do not count towards Your Out-of-Pocket Maximum.

Individual and Family Out-of-Pocket maximums are listed in the Schedule of Benefits.

1.6 Maximum Lifetime Benefit

The maximum lifetime benefit payable per Member, if applicable, is listed in the Schedule of Benefits.

1.7 How to Contact the Health Plan

Throughout this Evidence of Coverage, You will find that We encourage You to contact Us for further information. Whenever You have a question, or concern regarding Covered Services, or any required procedure, please contact Us at the telephone number on Your identification card.

Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers and Addresses included in this Agreement.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

PURSUANT TO THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If You elect breast reconstruction in connection with a mastectomy, You are entitled to coverage under the Agreement for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such services will be performed in a manner determined in consultation with the attending physician and the patient. See Section 5 for further detail regarding this coverage.

SECTION 2
ENROLLMENT AND ELIGIBILITY

2.1 Eligibility

2.1.1 Subscriber Eligibility - To be eligible to be enrolled You must:

- Live or work in the Service Area at least nine (9) months out of the calendar year, unless you are on a temporary work assignment of six (6) months or less; and

- Be an employee or Retiree of the Group; and

- Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of Your own status with the Group, and not by virtue of dependency; and

- Meet any eligibility criteria specified by the Group and approved by the Health Plan, including, without limitation, the criteria set forth in Section 2.2 below (Retiree); and

- Complete and submit to the Health Plan such applications or forms that the Health Plan may reasonably request.

2.1.2 Dependent Eligibility - To be eligible to be enrolled under the Agreement as a Dependent, an individual must:

- Live in the Health Plan Service Area at least nine (9) months out of the year, except as permitted under section e) below, and

- Be the lawful spouse of the Subscriber, an unmarried child of the Subscriber, or the Subscriber's spouse including:

  a) Children under age nineteen (19) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;

  b) Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to Qualified Medical Child Support order,

  c) Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;

  d) Children nineteen (19) or older who are either the birth or adopted children of the Subscriber or the Subscriber's spouse, are mentally

or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity is furnished to Us by the Subscriber upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age nineteen (19) and annually thereafter;

e) Children under the age of twenty-three (23) or the age set forth in the Group Master Contract who are either the birth or adopted children of the Member and are attending on a full-time basis an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program on a full-time basis, provided that the Subscriber provides documentation of such attendance to the Health Plan upon request. Coverage ends the last day of the month in which the dependent attains the age of twenty-three (23) or the age set forth in the Group Master Contract, or is no longer enrolled in school on a full-time basis.

Notwithstanding the above, a common law spouse qualifies as a spouse under the Agreement only if his/her spousal status is affirmed by a court of competent jurisdiction.

2.2 Retirees

A Retiree or Retiree spouse who is eligible to be covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B coverage on the later of the date he/she is first eligible for Medicare or the effective date of the Agreement in order to be eligible or continue coverage under the Agreement. If a Retiree or a Retiree spouse does not enroll within thirty (30) days of the later of the date he/she is first eligible for Medicare or the effective date of the Agreement, his/her coverage under the Agreement shall terminate.

2.3 Change of Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as the Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by the Health Plan.

2.4 Persons Not Eligible to Enroll

2.4.1 A person who fails to meet the eligibility requirements specified in the Agreement shall not be eligible to enroll or continue enrollment with the Health Plan for coverage under this Agreement.

2.4.2 A person whose coverage under the Agreement was terminated due to a violation of a material provision of the Agreement shall not be eligible to enroll with the Health Plan for coverage under the Agreement.

2.4.3 Late Enrollees are not eligible to enroll except during the next Group Enrollment Period or if eligible for a special enrollment (see Section 2.6).

2.5 Enrollment

2.5.1 Group Enrollment Period: All eligible employees or Retirees of a Group and their eligible Dependents may enroll with the Health Plan for coverage under the Agreement during the Group Enrollment Period or a Special Enrollment Period.

2.5.2 Any new employee or employee who transfers into the Health Plan Service Area may enroll with the Health Plan for coverage under the Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit a Health Plan Enrollment Application for purposes of enrolling with the Health Plan for coverage under the Agreement within thirty-one (31) days after becoming eligible, he/she is not eligible to enroll until the next Group Enrollment Period.

2.5.3 A special enrollee may enroll with the Health Plan for coverage under the Agreement as provided below.

2.5.4 Eligible employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under the Agreement are not eligible to enroll until the next open enrollment period, unless they are eligible to enroll as a special enrollee, as described in Section 2.6 below.

2.6 Special Enrollment

2.6.1 Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an employee and his or her dependents may enroll in this Health Plan if the employee waived initial coverage under this Health Plan at the time coverage was first offered because the employee or dependent had other coverage at the time coverage under this Health Plan was offered and the employee's or dependent's other coverage was:

- COBRA continuation coverage that has since been exhausted; or,

- If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (e.g., including but not limited to fraud or

intentional misrepresentation).

Required Length of Special Enrollment**.** An employee and his or her Dependents must request special enrollment in writing no later than thirty (30) days from the date that the other coverage was lost.

Effective Date of Coverage**.** If the employee or dependent enrolls within the thirty (30) day period, coverage under the Health Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for special enrollment is received.

2.6.2 Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- Non-participating Employee**.** An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

- Non-participating Spouse**.** A spouse may enroll at the time of marriage to a Subscriber, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).

- New Dependents of Subscriber**.** A child who becomes a Dependent of a Subscriber as a result of marriage, birth, adoption or placement for adoption may enroll at that time.

- New Dependents of Non-enrolled Employee**.** A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.

Required Length of Special Enrollment**.** An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage. Coverage shall become effective:

- In the case of marriage, the first (1st) day of the first (1st) calendar month beginning after the date a completed Enrollment Form is received by the Health Plan; and

- In the case of a Dependent's birth, the date of such birth as described in

Section 3.2.2; and

- In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

2.7 Notification of Change in Status. A covered employee must notify the Health Plan of any changes in Your status or the status of any Dependent within thirty (30) days after the date of the qualifying event. This notification must be submitted on a written Change of Status form to Customer Service or the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, Dependent status, Medicare eligibility or coverage by another payer. The Health Plan should be notified within a reasonable time of the death of any Member.

SECTION 3
EFFECTIVE DATES

3.1 Effective Date

3.1.1 **During Group Enrollment Period**: An employee or Retiree who is eligible for coverage under the Agreement and enrolls during a Group Enrollment Period shall be covered under the Agreement as of the Member Effective Date, a date mutually agreed to by the Health Plan and the Group.

3.1.2 **Newly Hired Employees**: A newly hired employee who is eligible for coverage shall be covered under the Agreement as of the date that he/she first becomes eligible for coverage so long as the Health Plan receives the employee's completed Enrollment Form within thirty-one (31) days of the date that the employee first became eligible for coverage.

3.1.3 **Newly Eligible Employees**: An employee of the Group who transfers into the Service Area, and had been otherwise eligible for coverage under the Agreement shall be covered as of the first (1^{st}) day of the month following the date that he/she first transfers into the Service Area so long as the Health Plan receives the employee's Enrollment Form within thirty-one (31) days of the date that the employee first become eligible for coverage.

3.1.4 **Special Enrollees**: Special enrollees shall be covered under the Agreement as provided in Section 2 above.

3.2 Member Effective Date for Dependents

3.2.1 Dependents may be enrolled during a Group Enrollment Period or upon the valid enrollment of a newly hired or newly eligible employees (as provided in Section 3.1 above). In the case of Dependents who are enrolled during the Group Enrollment Period or upon the valid enrollment of a newly hired or eligible employee, the Dependent Effective Date shall be the same as the Member Effective Date.

3.2.2 Dependents who are special enrollees shall be covered under the Agreement when stated in Section 2.6 above; provided that a child born to a Subscriber is automatically covered for the treatment of injury or sickness, including medically diagnosed congenital defects, and birth abnormalities, for the first thirty-one (31) days from the date of birth. Applicable premiums must be paid for this coverage. For coverage to continue beyond the first thirty-one (31) days, application to add the child as a Dependent must be received within thirty-one (31) days from the date of birth. Any newborn that is automatically covered for the first thirty-one (31) days from the date of birth but is not

eligible to enroll as a Dependent under the Agreement may convert to an individual contract under the terms and conditions set forth in Section 9 of this Evidence of Coverage. Dependents eligible for coverage as a result of a Qualified Medical Child Support Order shall be covered as of the date specified in the order. If no date is specified in the order, coverage shall be effective as of the date the order is issued by the court.

3.3 Inpatient on the Member Effective Date

Notwithstanding anything in this Evidence of Coverage to the contrary, coverage for any person who is confined as an inpatient in any Hospital, Skilled Nursing Facility or Hospice on the date such person is to become a Member will not begin until such person has been discharged, unless: (i) such services are not covered under a prior group agreement; and (ii) such person agrees to come under the care of the Health Plan Participating Providers on the Member Effective Date, and (iii) all services are provided, prescribed and/or ordered by a Health Plan Participating Provider.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Coverage For Members

Your coverage shall terminate upon the occurrence of any one of the following events:

- At least thirty (30) days notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in the Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under the Agreement.

- At least thirty (30) days notice of termination of a Retiree or the Retiree spouse if the Retiree or the Retiree spouse is eligible to enroll in Medicare (Title XVIII of the Social Security Act as amended) and fails to enroll in Medicare Part A and B coverage within thirty (30) days of the later of the date that the Member first becomes eligible to enroll or the Member Effective Date;
- At least thirty (30) days notice of the termination of Your Coverage due to the nonpayment of premiums to Health Plan or supplemental charges required for Hospital or other medical services (e.g., Copayments, Coinsurance, Deductibles). In the case of termination due to nonpayment of premium, the termination shall become retroactively effective on the day after the last day for which premiums have been paid in full for the entire group. In the case of termination due to failure to pay supplemental charges, the termination shall become effective on the date stated in the written notice, which date shall be on or after the 30th day following the date of the notice;
- Upon the termination or non-renewal of the Group Master Contract, by the Group;

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    - If a Dependent fails to establish a satisfactory patient-physician relationship, only the coverage of the Dependent shall be terminated. If the Subscriber fails to establish a satisfactory patient-physician relationship, the coverage of the Subscriber and his/her Dependents will be terminated.

    - Immediately upon Your receipt of written notice of Your termination if You participate in fraudulent or criminal behavior, including but not limited to:

        - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification

card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, coverage for the Subscriber and all Dependents will be terminated.

- Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the coverage of the Subscriber and his/her Dependents will be terminated.
- Threatening or perpetrating violent acts against the Health Plan, a Provider, or an employee of the Health Plan or a Provider. In this instance, coverage for the Subscriber and all Dependents will be terminated.
- Knowingly misrepresenting or giving false information on any Enrollment Form which is material to the Health Plan's acceptance of such application.

4.2 Effect of Termination.

If Your coverage under the Agreement is terminated under Section 4.1, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

Identification cards are the property of the Health Plan, and upon request, shall be returned to Us within thirty-one (31) days of the termination of Your coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

Your coverage cannot be terminated on the basis of the status of Your health or the exercise of your rights under the Health Plan's Grievance and Complaint procedures. The Health Plan may not terminate the Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

SECTION 5
COVERED SERVICES

The Health Plan covers only those health services, supplies, drugs, and equipment that are (1) listed in section 5 below, (2) deemed Medically Necessary, (3) provided by a Participating Provider (under the Health Maintenance Network Coverage Option) or a Non-Participating Provider (under the Out-of-Network Coverage Option) , and (4) not excluded under the Exclusions and Limitations set forth in Section 6 or elsewhere in this Evidence of Coverage.

Transplants must be rendered by a Coventry Transplant Network Facility.

The following section of Covered Services lists the health care services, supplies, equipment, and drugs covered under the Agreement. The section is provided to assist You with determining the level of coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the Exclusions and Limitations set forth in Section 6. All Prior Authorizations and determinations referenced in Covered Services are made by Us. If a service is Medically Necessary but not specifically listed and not otherwise excluded, please contact Us to confirm whether the service, supply, drug, or equipment is a Covered Service.

5.1 Table of Covered Services

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections when Medically Necessary.	Prior Authorization required if services are provided in an inpatient or outpatient facility.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Ambulance	Covered Service for ground ambulance to Hospital when ambulance travel is determined to be Medically Necessary. Covered Service for air ambulance when Medically Necessary due to an Emergency Medical Condition.	Prior Authorization required unless related to Emergency Services.
Blood and Blood Products Administration	Covered Service for administration, storage, and processing of blood and blood products in connection with Medically Necessary services.	Prior Authorization only required when provided as an outpatient. When You are an inpatient, additional Authorization is not required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Breast Reconstruction	Covered Service consistent with the Women's Health and Cancer Rights Act of 1998, if You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage will be provided for: • Reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Breast prostheses and physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation between You and Your attending Physician.	Prior Authorization required.
Cardiac Rehabilitation Therapy	Covered Service, but limited to treatment for therapy conditions that in the judgement of a Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.
Chemotherapy and radiation therapy	Covered Service.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Dental & Oral Services	Coverage benefit limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums. Covered Service for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate.	Prior Authorization required. Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial, except in the case of severe trauma), root canal treatment, surgery for impacted teeth, surgery involving structures directly supporting the teeth, or orthodontia. Additional exclusions in Section 6.
Dermatological Services	Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.	Prior Authorization recommended for medical necessity and benefit determination.
Dialysis	Covered Service for hemodialysis and peritoneal services provided by participating outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	Prior Authorization required.
Disposable Supplies	Not Covered, except for: (i) ostomy; (ii) disposable diabetic supplies; and/or (iii) supplies used in addition to or as part of a piece of Covered Durable Medical Equipment (DME), if the supplies are needed to ensure proper functionality of the Covered DME.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Durable Medical Equipment (DME)	Covered Service when determined to be Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply: (1) it can withstand repeated use; (2) it is primarily and customarily used to serve a medical purpose; (3) it is generally not useful to a person in the absence of illness or injury; and (4) it is appropriate for use in the home.	Prior Authorization required. Consult the Schedule of Benefits for additional limitations. Glucometers must be obtained from Coventry Health Care of Nebraska's national vendor.
Elective Sterilization	Covered Service.	Prior Authorization required if services are provided in an inpatient or outpatient facility.
Emergency Services	Covered Service as set forth in Section 5.2. The Health Plan definition of "Emergency Services", "Emergency Medical Condition", and "Emergency Out of Area" are found in the definition section.	While Emergency Room visits do not require Prior Authorization from or notification to Us, You should notify Us as soon as physically possible.
Eyeglasses and Corrective Lenses	Not a Covered Service, except when Medically Necessary for the first pair of eyeglasses or corrective lenses following cataract surgery.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Family Planning	Covered Service includes counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and Norplant, measurement for contraceptive diaphragms and services related to outpatient contraceptive services for the purpose of preventing conception.	Prior Authorization required if services are provided in an inpatient or outpatient facility.
Genetic Counseling	Covered Service for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities.	Prior Authorization required.
Growth Hormone	Covered Service.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Home Health Care	Covered Service when all of the following requirements are met: (1) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; (2) the services are a substitute or alternative to hospitalization; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; (5) the services are Medically Necessary and Authorized for Coverage by Us; and (6) the agency rendering services is Medicare certified and licensed by the State of location.	Prior Authorization required.
Hospice	Covered Service when all the following requirements are met: (1) when in the judgement of a Physician, the Member's life expectancy is six (6) months or less; (2) services are Authorized for Coverage by Us; and (3) provided by a state licensed hospice.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Immunizations	Covered Service.	Immunizations for routine childhood immunizations and flu shots performed by a Participating Provider do not require Prior Authorization by Us. Prior Authorization required for immunizations other than routine childhood immunizations (e.g., Lyme Disease). Immunizations for travel, employment, or post high school education are not Covered.
Infertility	Covered Service only for the diagnosis of Infertility.	Prior Authorization required. Treatment of Infertility is not Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Inpatient Hospital Care	Covered Service includes: (1) room and board; (2) general nursing care; (3) use of equipment and supplies; (4) use of operating room/recovery room/treatment room; (5) semi-private room or private room when Medically Necessary; (6) intensive care, coronary care unit and related Hospital services; (7) anesthesia services and supplies; (8) laboratory and radiology examinations; and (9) medication used while inpatient.	Prior Authorization required unless Emergency Medical Condition or Emergency Services admission. Consistent with Our utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, Your Provider will be notified that Coverage will cease.
Inpatient Nursing Facility	Covered Service only when the services are a substitute or alternative to hospitalization. Coverage includes, but is not limited to, medical supplies, equipment, drugs and biologicals ordinarily furnished by the Inpatient Nursing Facility.	Prior Authorization required. Days per Member per calendar year are limited if listed in Your Schedule of Benefits. Custodial care is excluded.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Laboratory Services	Covered Service.	Prior Authorization required for genetic testing and thin prep gynecologic screening.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Maternity Services	Covered Service for the professional prenatal and postpartum period and during Hospital confinement. Maternity services include a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean delivery. This does not prevent the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If a mother and newborn are discharged earlier than 48 hours following a vaginal delivery or earlier than 96 hours following a cesarean delivery, coverage will be provided for up to two follow-up visits, provided that the first such visit occurs within 48 hours of discharge. The second follow-up visit will be Covered only if the Provider in consultation with the mother determines that a second visit is Medically Necessary. Newborn children are covered from the date of birth for a period of thirty-one (31) days. An Enrollment Form must be submitted to the Health Plan for continued coverage after thirty-one (31) days.	Prior Authorization required for Hospital length of stay in connection with childbirth for the mother and newborn in excess of forty-eight (48) hours following a normal vaginal delivery and in excess of ninety-six (96) hours following a caesarian section.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Medical Complications	Covered Service for complications arising from Medically Necessary surgery for Covered Services, regardless of Health Plan membership status at the time of surgery.	Prior Authorization Required. Not a Covered Service if complications occurred when You did not follow the course of treatment prescribed by a Provider. Not a Covered Service if the complications arise from Non-Covered Services. Although the requested service may be Medically Necessary, if the complication is related to or as a result of a non-Covered Service, the requested service will be denied for Coverage.
Mental Health Services	See Section 5.4.	
Nutritional Counseling	Covered Service when provided by a Registered Dietician or Physician.	Prior Authorization required.
Occupational Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function or impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement will be achieved through relatively short-term therapy.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS.**
Orthotics	Covered Service when determined to be Medically Necessary by Us and: (1) is primarily and customarily used to serve a medical purpose; (2) can withstand repeated use; and (3) is Authorized for Coverage by Us.	Prior Authorization required. Except in the case of diabetics foot orthotics are not Covered. Coverage for orthotic devices will be through the DME benefit.
Physical Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function or impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement will be achieved through relatively short-term therapy.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.
Podiatry	Covered Service when determined to be Medically Necessary. Foot care for diabetics is a Covered Service.	Prior Authorization required if services are provided in an inpatient or outpatient facility. Except in the case of diabetics, not a Covered Service for foot care including but not limited to removal or reduction of corns and calluses, clipping of toenails, treatment of flat feet, fallen arches, and chronic foot strain.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS**
Preventive, Diagnostic and Treatment Services	Covered Services include, but are not limited to: (1) Preventive care, including well-baby care and periodic check-ups according to the preventive care guidelines adopted by the Health Plan. (2) Diagnosis and treatment of illness or injury. (3) Injectables normally rendered in a physician's office. (4) Consultations with Specialists. (5) Laboratory tests, when obtained at a Provider of laboratory services. (6) See Maternity coverage. (7) PSA test, one in a twelve (12) month period and digital rectal examinations, all in accordance with American Cancer Society Guidelines. (8) Colon cancer screening (9) Well-woman care: One pap smear in a twelve month period and low-dose screening mammograms for determining the presence of breast cancer in accordance with guidelines of Health Plan.	Care that is not an Emergency Medical Service must be provided by a Participating Provider (under the Health Maintenance Network Coverage Option) or a Non-Participating Provider (under the Out-of-Network Coverage Option).

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS**
Prosthetic Devices	Initial prosthetic device is a Covered Service when determined to be Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part. A refitting and replacement is only covered when determined to be Medically Necessary.	Prior Authorization required. Coverage for prosthetic devices will be through the DME benefit subject to any maximum benefit.
Pulmonary Rehabilitation Therapy	Covered Service, but limited to treatment for conditions that in the judgment of a Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.
Radiology	Covered Service.	Prior Authorization required for MRA and PET scans.
Reconstructive Surgery	Covered Service for repair of disfigurement resulting from an injury, reconstruction incidental to surgery, and surgery that substantially improves functioning of any malformed body part.	Prior Authorization required.
Second Surgical Opinion	Covered Service.	Prior Authorization is not required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED.**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, EXCLUSIONS**
Sleep Studies	Covered Service.	
Speech Therapy	Covered Service when determined to be Medically Necessary to restore speech loss or speech impairment due to trauma, stroke, a surgical procedure, child's hearing condition or other acute condition, and significant improvement is expected to be achieved through relatively short-term therapy.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.
Spinal Manipulation	Covered Service for spinal manipulation and adjustments.	Prior Authorization required. Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.
Surgical Services	Covered Service.	Prior Authorization required. For oral surgery services, see Dental and Oral Services.
Transplants	See Section 5.6.	Prior Authorization required

5.2 Emergency Benefits

In the event You experience an Emergency Medical Condition, seek help immediately at the nearest Participating Hospital, Participating Physician's office, or other Participating emergency facility. If You are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would create a danger to Your health,

You should obtain medical attention from the nearest Hospital or through 911 emergency services (where available). Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and do not require Prior Authorization.

You should contact Us as soon as is reasonably possible under the circumstances. The determination of Covered Services for services rendered in an emergency facility is based on Our review of Your emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care.

5.2.1 What is an Emergency Medical Condition?

"Emergency" means the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in one of the following:

(a) placing the Member's health in jeopardy;

(b) placing the health of a pregnant Member and the health of her unborn child in serious jeopardy;

(c) serious impairment to bodily function;

(d) serious or permanent dysfunction to a body organ or part; or

(e) other serious medical consequences.

An Emergency Medical Condition is the sudden onset of acute symptoms of sufficient severity (including pain) which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention would result in serious jeopardy to the health of the individual (or unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

5.3 Mental Health, Alcohol and Drug Abuse Services Benefits

The Health Plan covers mental health, alcohol and drug abuse services when listed on the Schedule of Benefits or when a Mental Health and Substance Abuse Rider is purchased. The Health Plan contracts with an outside vendor for the provision of mental health care services, including, the coordination of care, the determination of Medical Necessity, the pre-authorization of treatment, and the arrangement of the diagnosis and treatment of all biologically based mental illnesses, psychiatric conditions, and substance abuse (“Mental Health and Substance Abuse”).

If You have any questions about Your Mental Health and Substance Abuse Coverage or the appropriate way to access Coverage, please either contact the mental health

vendor or the Health Plan at (800) 288-3343. The following services are Covered:

5.3.1 Medically Necessary outpatient visits to Participating Providers as may be necessary and appropriate for short-term evaluative or crisis intervention services. A benefit maximum applies to treatment that is not related to biologically based mental illness. Coverage limits for the treatment of biologically based mental illness will be the same as coverage under the medical and surgical benefits for any other illness, condition, or disorder. You should consult the Schedule of Covered Services to determine the amount of Your payment responsibility per visit and any applicable benefit maximum.

Medically Necessary inpatient care at a Participating Provider. A benefit maximum applies to treatment that is not related to biologically based mental illness, including but not limited to inpatient days for substance abuse detoxification and rehabilitation not related to a biologically based mental illness. Coverage for the treatment of biologically based mental illness will be the same as coverage under the medical and surgical benefits for any other illness, condition, or disorder.

5.4 Transplant Services

Services related to Medically Necessary organ transplants are covered when approved by Us and performed at a Coventry Transplant Network Facility approved by Us.

Donor screening tests are covered and are subject to a benefit maximum of $10,000 when performed at a facility approved by Us.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered individual will be covered for the duration of the contract of the covered individual when approved by Us.

The cost of any care, including complications, arising from an organ donation by a covered individual when the recipient is not a covered individual is excluded.

Travel expenses for members and living donors are covered according to the Coventry Health Care transplant travel benefit. Members are covered when Coventry Health Care is the primary insurer and a Coventry Transplant Network Facility is used.

SECTION 6

EXCLUSIONS AND LIMITATIONS

6.1 Generally excluded services/items

Generally excluded services/items include:

6.1.1 Any service, supply, equipment, drug, or procedure that is not coordinated in accordance with Our utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Evidence of Coverage;

6.1.2 Any service, supply, equipment, drug, or procedure that is not Medically Necessary;

6.1.3 Any service, supply, equipment, drug, or procedure that is not a Covered Service;

6.1.4 Any service, supply, equipment, drug, or procedure for the treatment of smoking cessation;

6.1.5 Any service, supply, equipment, drug, or procedure for which You have no financial liability or that was provided at no charge;

6.1.6 Any service, supply, equipment, drug, or procedure furnished under or as part of a study, grant, or research program; and

6.1.7 Any service, supply, equipment, drug, or procedure rendered or utilized as a result of injuries sustained during the commission of an illegal act.

6.2 Specifically excluded services/items

Specifically excluded services include:

6.2.1 Abortions, except when the life of the mother would be endangered if the fetus were carried to term;

6.2.2 Acupuncture, accupressure;

6.2.3 Ambulance service for non-emergencies;

6.2.4 Ambulance service except as outlined in the Schedule of Benefits;

6.2.5 Any item, or technology requiring federal, or other government agency approval that has not been granted at the time services are rendered;

6.2.6 Any cost in excess of the Out-of-Network Rate for charges incurred at a Non-Participating Provider;

6.2.7 Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

6.2.8 Behavior modification;

6.2.9 Biofeedback;

6.2.10 Bionics, special shoes, sunglasses, corsets, clothing;

6.2.11 Braces and supports needed for athletic participation or employment;

6.2.12 Breast augmentation or reduction which is not associated with cancer of the breast;

6.2.13 Breast pumps;

6.2.14 Care rendered to You by a relative;

6.2.15 Charges resulting from Your failure to appropriately cancel a scheduled appointment;

6.2.16 Cochlear Implants;

6.2.17 Complications that result from not following the course of treatment prescribed by a Participating Provider;

6.2.18 Cosmetic services and surgery and the complications incurred as a result of those services and surgeries;

6.2.19 Court-ordered services or services that are a condition of probation or parole;

6.2.20 Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, convalescent care, respite care;

6.2.21 Day care;

6.2.22 Dental care, appliances, implants, crowns, bridges, dentures, or other prosthetic devices, dental restorative care, periodontal care, treatment of impacted wisdom teeth, orthodontics, treatment for temporomandibular joint dysfunction (TMJ), orthognathic surgery, or X-rays, including, but not limited to, any Physician services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums; Routine Dental care may be covered if a Supplemental Dental Rider has been purchased; Treatment for TMJ may be covered if a Supplemental Rider has been purchased;

6.2.23 Disposable items;

6.2.24 Dynamic Orthotic Cranioplasty (DOC) Bands, Cranial Orthosis, Molding Helmet Therapy, or surgical treatment of Deformational (Nonsynostotoic) Plagiocephaly;

6.2.25 Educational testing, or psychological testing, unless part of a treatment program for Covered Services;

6.2.26 Emergency room services for non-emergencies;

6.2.27 Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage;

6.2.28 Exercise equipment, rental or purchase;

6.2.29 Eye examinations for refractive correction unless listed in the Schedule of Benefits or provided in a Supplemental Benefit Rider;

6.2.30 Eye exercises and therapy; fitting or cost of visual aids;

6.2.31 Eye glasses and corrective lenses, except as necessary for the initial placement of corrective or contact lenses following cataract surgery performed while a Member of the Plan;

6.2.32 Food supplements, including but not limited to, infant formulas;

6.2.33 Foot care, including but not limited to removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, and chronic foot strain except in the case of diabetics;

6.2.34 Foot orthotics except in the case of diabetics;

6.2.35 Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities;

6.2.36 Hair analysis;

6.2.37 Hair prostheses;

6.2.38 Hearing aids, including the cost and fitting;

6.2.39 Home services to help meet personal, family, or domestic needs; such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, or taking medications;

6.2.40 Humidifiers, de-humidifiers, air-conditioners, space heaters, or any other equipment, or service used in altering air quality or temperature;

6.2.41 Hypnotherapy;

6.2.42 Immunizations for travel, employment, or post high school education;

6.2.43 Infertility services, supplies, equipment, procedures and drugs;

6.2.44 Learning disabilities treatment;

6.2.45 Long-term care and all services provided by such facilities;

6.2.46 Marriage or relationship counseling; family counseling; vocational, or employment counseling; sex therapy; and sex counseling;

6.2.47 Massage therapy;

6.2.48 Mental health services unless listed on the Schedule of Benefits or provided in a Supplemental Benefit Rider;

6.2.49 Newborn home delivery;

6.2.50 Oral Surgery: required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthoganathic or prognathic surgical procedures, involving removal of symptomatic bony impacted third molars; orthodontia and related services;

6.2.51 Orthotic and prosthetic replacement and repair unless deemed Medically Necessary by Us;

6.2.52 Over-the-counter supplies and drugs such as, but not limited to, ACE wraps, elastic supports, finger splints, wrist splints, orthotics;

6.2.53 Patient lifts, including but not limited to chair lifts, seat lifts, and bed lifts;

6.2.54 Penile prostheses;

6.2.55 Personal comfort and convenience items such as but not limited to, television, telephone, tissue, razor, toothbrush, toothpaste;

6.2.56 Prescription drugs unless listed in the Schedule of Benefits or provided in a Supplemental Benefit Rider;

6.2.57 Private duty nursing;

6.2.58 Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable;

6.2.59 Procedures and treatments that We determine, in our sole and absolute discretion, to be Experimental or Investigational, and treatment of complications resulting from such procedures and treatments;

6.2.60 Psychiatric evaluation, or therapy when related to judicial, or administrative proceedings, or orders when employer requested, or when required for school;

6.2.61 Psychoanalysis;

6.2.62 Radial keratotomy, laser eye surgery or similar surgery done to treat myopia;

6.2.63 Removal of skin lesions, unless lesions interfere with normal bodily functions, or a malignancy is suspected;

6.2.64 Retroactive Referrals;

6.2.65 Self-inflicted (intentional) injury or sickness, suicide, or suicide attempt;

6.2.66 Services that are paid by, or recovered amounts specifically for, medical expenses from a third party or insurance carrier;

6.2.67 Services the Member is entitled to under Medicare even if the Member is not enrolled;

6.2.68 Short-term therapy that exceeds the limits listed in the Schedule of Benefits;

6.2.69 Sleep therapy;

6.2.70 Sterilization reversal and any service, supply, equipment, drug, or procedure related to sex transformation, surrogate childbirth, egg or sperm donation, cryopreservation, in vitro fertilization, and storage of sperm, eggs and embryos;

6.2.71 Surgery performed solely to address psychological or emotional factors;

6.2.72 Surrogate motherhood services and supplies, including, but not limited to, all

services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

6.2.73 Transplant services, and any related conditions or complications, for a Member who is donating an organ or tissue when the recipient is not a Member;

6.2.74 Travel expenses, other than Medically Necessary transportation authorized for Coverage by Us;

6.2.75 Treatment for behavioral conditions not attributable to a Mental Disorder described in the Diagnostic and Statistical Manual Published by the American Psychiatric Association as "V" codes, such as but not limited to, relational problems, anti-social behavior, academic problems and phase-of-life problems;

6.2.76 Treatment for delirium, dementia, amnesia or cognitive disorders with psychiatric manifestations or conditions;

6.2.77 Treatment of mental retardation, unless covered as a biologically-based mental illness;

6.2.78 Treatment for mental retardation and disorders relating to: learning, motor skills, communication, pervasive developmental conditions such as, but not limited to, autism, feeding and eating disorders in infancy and early childhood;

6.2.79 Treatment for substance abuse unless Covered under a Supplemental Benefit Rider;

6.2.80 Vision care and optometric services;

6.2.81 Vocational therapy;

6.2.82 War or acts of war;

6.2.83 War related sickness, injury, and services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran Administration services and for which facilities are reasonably accessible to You;

6.2.84 Weight reduction supplies, services, equipment, drugs, therapy and procedures, including but not limited to, diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature;Whole blood and blood products replacement to a blood bank;

6.2.85 Work hardening programs; and

6.2.86 Work related injuries or illnesses if they are covered under worker's compensation or similar law.

SECTION 7
COORDINATION WITH OTHER COVERAGE
(COORDINATION OF BENEFITS-COB)

7.1 Coordination With Other Plans

This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan, will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

7.2 Definitions

7.2.1 A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

7.2.1.1 "**Plan**" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

7.2.1.2 "**Plan**" does not include: individual or family insurance; close panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

7.2.1.3 Each contract for coverage under Section 7.2.1.1 or 7.2.1.2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

7.2.2 The order of benefit determination rules determine whether We are a "**Primary**" Plan or "**Secondary**" Plan when compared to another Plan covering You or Your Covered Dependent. When We are Primary, Our

benefits are determined before those of any other Plan and without considering any other Plan's benefits. When We are Secondary, Our benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

7.2.3 "**Allowable Expense**" means a health care service or expense including deductibles and copayments, that is covered, at least in part by any of the Plans covering You or Your Covered Dependent**.** When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. Expenses for dental care, vision care, prescription drugs, and services that are not covered by any of the Plans are not Allowable Expenses under this provision. The following are examples of expenses or services that are not Allowable Expenses:

7.2.3.1 If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is otherwise a covered benefit) is not an Allowable Expense.

7.2.3.2 If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

7.2.3.3 If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

7.2.3.4 The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

7.2.4 "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which a Member has no coverage under this Health Plan, or before the date this COB provision or a similar provision takes effect.

7.2.5 "**Closed Panel Plan**" is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

7.2.6 "**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

7.3 Order of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

7.3.1 The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

7.3.2 A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

7.3.3 A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

7.3.4 The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

7.3.4.1 **Non-Dependent or Dependent**. The Plan that covers the Member other than as a dependent, for example as an employee, member, subscriber or retiree is Primary and the Plan that covers the Member as a dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Member as a dependent; and Primary to the Plan covering the Member as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, subscriber or retiree is Secondary and the other Plan is Primary.

7.3.4.2 **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one Plan is:

i. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever

have been married); or

- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.

ii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

iii. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the Custodial Parent;
- The Plan of the spouse of the Custodial Parent;
- The Plan of the non-custodial parent; and then
- The Plan of the spouse of the non-custodial parent.

7.3.4.3 **Active or inactive employee.** The Plan that covers a Member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Member is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7.3.4.4 **Continuation coverage**. If a Member whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree (or as that Member's dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7.3.4.5 **Longer or shorter length of coverage**. The Plan that covered the Member as an employee, member, subscriber or retiree longer is Primary.

7.3.4.6 If the preceding rules do not determine the Primary Plan, the Allowable

Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, We will not pay more than we would have paid had We been Primary.

7.4 Effect On The Benefits of this Health Plan

7.4.1 When We are Secondary, we may reduce Our benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that We would have paid had We been the Primary Plan, and the benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by Us to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, We will:

7.4.1.1 Determine Our obligation to pay or provide benefits under its contract;

7.4.1.2 Determine whether a benefit reserve has been recorded for You or Your Covered Dependent; and

7.4.1.3 Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Member's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claims Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

7.5 Coordination of Benefits with Medicare

7.5.1 Active Employees and Spouses Age 65 and Older

If an employee is eligible for Medicare and works for a Group with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis.

If an employee works for a Group with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, the Health Plan will be primary. However, an Employee may decline coverage under this Health Plan and elect Medicare as primary. In this instance, this Health Plan, by law, cannot pay benefits secondary to Medicare for Medicare Covered Services.

You will continue to be covered by this Health Plan as primary unless You (a) notify Us, in writing, that You do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

7.5.2 Disability

If You are under age 65 and eligible for Medicare due to disability, and actively work for a Group with fewer than 100 employees, then Medicare is the primary payer. This Health Plan will pay benefits on a secondary basis.

If You are age 65 or older and actively work for a Group with at least 100 employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) this Health Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

7.5.3 End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. If this Health Plan is currently paying benefits as secondary, this Health Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

7.5.4 Coordination of Benefits for Retirees

If You are retired and You or one of Your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Evidence of Coverage will be paid after:

7.5.5 Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;

7.5.6 Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been covered by Medicare; or

7.5.7 Amounts paid under all other plans in which You participate.

7.6 Right to Receive and Release Needed Information

7.6.1 By accepting Coverage under the Agreement You agree to:

- Provide Us with Information about other coverage and promptly notify Us of any coverage changes;
- Give Us the right to obtain information as needed from others to coordinate benefits

Return any excess amounts to Us if We make a payment and later find that the other Coverage

should have been primary.

SECTION 8
CONTINUATION OF COVERAGE

8.1 Continuation Of Coverage for Certain Subscribers and Dependents

You are eligible to retain coverage under this Group Contract during any continuation of coverage period required under applicable federal or state law or regulation, provided that during such required continuation of coverage period You comply with the terms and conditions of the Group Contract and the premiums for such coverage continues to be paid by the Group pursuant to the terms of the Group Contract, COBRA and any other applicable federal or state law or regulation.

Coverage shall automatically terminate at the end of the minimum period of time required by COBRA or other applicable federal or state law or regulation.

You should contact the Group for the answers to any questions You have with respect to continuation of coverage.

You should also refer to Section 9 for any conversion privilege You may have at the end of any period of continuation coverage.

SECTION 9
CONVERSION

If Your eligibility for group health coverage ends under the Agreement, You may convert to a non-group coverage on a direct-pay basis ("Conversion Coverage"). You will not have to provide proof of insurability. However, if the benefits under the Conversion Coverage are greater than the benefits under the Agreement, You may be asked to provide evidence of insurability for the greater benefits. You must apply for direct pay coverage within thirty-one (31) days after You lose group eligibility. Contact the Customer Service Department at (800) 288-3343, for information regarding conversion. The first premium must be received before Conversion Coverage will be put in force. Conversion Coverage will then be effective on the date that group coverage ends. In some cases, a Member can choose to continue group coverage for a period of time. In such a case, Conversion Coverage would be available after Group Coverage ends.

SECTION 10
COMPLAINTS AND GRIEVANCES

A Complaint may be directed to Us by telephone, in person, or in writing, expressing the details of Your concern. Complaints will be handled by a Customer Service Representative who may involve other staff members or Our Providers. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible, not to exceed thirty (30) calendar days. If the solution is satisfactory, the matter ends.

If You do not receive prompt resolution to a Complaint or wish to express further concern, You may file a verbal or written Grievance with Us. All Grievances must be submitted to Us within one-hundred-eighty (180) days after a notice of denial has been sent to You. Requests for appeals received after such one-hundred-eighty (180) calendar day period will not be eligible for review under the Health Plan's internal appeal process.

Appropriate Health Plan staff, none of which were involved in the initial adverse decision, will review your Grievance. You will be notified of Our decision in writing within fifteen (15) calendar days after receipt of Your Grievance. A First Level Grievance should not require more than fifteen (15) calendar days for completion. If the solution is satisfactory, the matter ends.

If the First Level Appeal solution is not satisfactory, within thirty (30) days, You may submit a verbal or written Second Level Appeal. Our Second Level Appeal Committee, none of which were involved in previous decisions, will review your concern. The Second Level Appeal Committee will convene within fifteen (15) calendar days of receiving Your request. The Second Level Appeal review process gives You the right to:

- appear before the Committee or communicate with the Committee via conference call or other available technology;
- present your case to the Committee;
- submit supporting material both before and during the Committee meeting;
- ask questions of any Committee members;
- be assisted or represented by a person of your choice; and
- upon your request, be provided with all relevant information that is not confidential or privileged.

After the review, You will be notified in writing of the Committee's decision within five (5) business days and within fifteen (15) calendar days from the receipt of the initial appeal.

If You are not satisfied with the decision of Our Second Level Appeal Committee, You may pursue normal remedies of the law. The suit or proceeding must be commenced no later than three (3) years after the date of notice of final determination.

When the timeframe of the Grievance procedures would seriously jeopardize the life or health of a Member or would jeopardize a Member's ability to regain maximum function, an **Expedited Appeal** may be filed either verbally or in writing. Expedited Appeal requests pertain to an admission, availability of care, continued stay, or health care service for a Member who has received emergency services but has not been discharged from a facility. Expedited Appeal procedures cannot be used for payment denials.

The Expedited Appeal will be reviewed by a clinical peer(s) and a decision will be made within one (1) business day. Verbal notification of Our decision will be forthcoming within one (1) business day and written notification within one (1) business day of verbal notification. If the Expedited Appeal is a concurrent review determination, the health care service shall be continued without liability to the Member until the Member has been notified of the determination. If the decision is adverse, You may appeal immediately to Our Second Level Appeal Committee. Within 48 hours an Expedited hearing will be held and You will be notified by telephone of the Committee's decision. Written confirmation of the Committee's decision will follow within one (1) business day of the verbal notification.

You and your Health Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

After you have exhausted the appeal rights provided by the Health Plan, you have the right to bring a civil action under ERISA Section 502(a).

Nebraska residents:

In case of a dispute about any part of the Agreement or if You encounter situations where the performance of the Health Plan does not meet Your expectations, Members who reside in Nebraska may contact the Department of Insurance at:

Nebraska Department of Insurance

941 O Street, Suite 400

Lincoln, NE 68508

(402) 471-2201

Iowa residents:

In case of a dispute about any part of the Agreement, Members who reside in Iowa may appeal Our final determination by contacting the Iowa Department of Insurance at:

Iowa Department of Insurance

330 Maple Street

Des Moines, IA 50319

(515) 281-5705

Should the decision of Our Second Level Appeal Committee be based on a determination of Medical Necessity, You have the right to file a written request for external review of Our Coverage decision with the Iowa Department of Insurance. This request must be filed within sixty (60) days of Your receipt of Our Coverage decision and must be accompanied by a twenty-five dollar ($25) filing fee and a copy of Our notice of the Committee's decision. The Iowa Insurance Commissioner may waive the filing fee for good cause. The filing fee shall be refunded to You if You prevail in the external review process.

SECTION 11
CONFIDENTIALITY OF YOUR MEDICAL RECORDS

As part of the Agreement, You agree to provide Us access to any records and medical information held by any provider of Covered Services. You also give Us, Our representatives, and authorized regulators or accrediting bodies access to Your general medical record for:

- claims processing, including claims We make on Your behalf for reimbursement;
- quality assessment and improvement;
- underwriting (for reinstating or adding a dependent); and
- evaluation of potential or actual claims against Us.

SECTION 12
RIGHT OF RECOVERY (THIRD PARTY LIABILITY SUBROGATION)

If You have a legal right to receive payment from an individual or organization because another party was responsible for Your illness, injury or other loss, We have a right of subrogation in any funds recovered as a result of this right. In other words, if You accept coverage for Covered Services under the Agreement, You must agree to reimburse Us in full for any benefits paid from any settlement, judgment or other payment You or Your attorney may receive as a result of Your personal injury. It does not matter how these payments are characterized, why they are paid, or whether they are labeled as being compensation for Your medical bills or lost wages.

You are obligated to cooperate with Us to protect Our subrogation rights. This cooperation includes: providing Us with relevant information, signing and delivering documents We reasonably request, and obtaining Our consent before releasing any party from liability. If You enter into litigation or settlement negotiations regarding the obligations of other parties, You must not prejudice, in any way, Our rights under subrogation proceedings. You or Your attorney most inform Us of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. The costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of Your legal representation shall be borne solely by You.

SECTION 13
DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Evidence of Coverage

13.1 "Agreement"

This Evidence of Coverage and amendments, the Enrollment Form, applicable Riders, and the Group Master Contract together form the Agreement.

13.2 "Authorization/Prior Authorization/Authorized"

The Health Plan has given approval for payment for certain services to be performed. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by the Health Plan. If You need specialty services from a Non-Participating Provider, an Authorization means the Member's Participating Provider has recommended a Non-Participating Provider for treatment of a specific condition, and the Health Plan has assigned an Authorization for a certain number of visits or days. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

13.3 "Coinsurance"

The percentage amount of Eligible Charges that will be paid by the Health Plan after any Deductible or Copayment has been deducted from the Eligible Charges. Coinsurance percentage amounts are set forth in the Schedule of Benefits.

13.4 "Contract Year"

The period during which the total amount of yearly benefits under Your coverage is calculated. The contract year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary.

13.5 "Copayment"

A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this Evidence of Coverage.

13.6 "Cosmetic"

Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

13.7 "Coventry Transplant Network Facility"

A Provider or Facility designated by Us to provide transplant services and treatment to Members.

13.8 "Cover" or "Covered" or "Coverage"

The entitlement by a Member to Covered Services under the Evidence of Coverage, subject to the terms, conditions, limitations and exclusions of the Evidence of Coverage, including the following conditions: (a) health services must be provided when the Evidence of Coverage is in effect; and (b) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Evidence of Coverage occur; and (c) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Evidence of Coverage; (d) health services must be Medically Necessary and (e) listed in Section 5 "Covered Services" of this Evidence of Coverage.
"Covered Services"

The services or supplies provided to You for which the Health Plan will make payment, as described in the Agreement.

13.9 "Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying before benefits subject to the Deductible are payable under the Agreement. The Out-of-Network Rate for Covered Services rendered under the Out-of-Network Coverage option and the Health Maintenance Network Coverage option may be calculated as one Deductible or two separate Deductibles. Refer to the Schedule of Benefits for Your coverage.

13.10 "Dependent"

Any member of a Subscriber's family who meets the eligibility requirements as outlined in this Evidence of Coverage.

13.11 "Directory of Health Care Providers"

A listing of Participating Providers. Please be aware the information in the directory is subject to change.

13.12 "Effective Date"

The date of Coverage as determined by the Group and agreed to by Us, as set forth in the Group Master Contract.

13.13 "Emergency Medical Condition"

"Emergency" means the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in one of the following:

(a) placing the Member's health in jeopardy;

(b) placing the health of a pregnant Member and the health of her unborn child in serious jeopardy;

(c) serious impairment to bodily function;

(d) serious or permanent dysfunction to a body organ or part; or

(e) other serious medical consequences.

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. serious jeopardy to the health of the individual (or unborn child) or in the case of a behavioral condition, placing the health of the individual or others in serious jeopardy;
2. serious impairment to any bodily functions;
3. serious impairment to any bodily organ or part;
4. serious disfigurement.

13.14 "Emergency Out of Area"

Covered Services provided when an enrollee is temporarily absent from the Service Area, that are immediately required as a result of:

1. an unforeseen illness, injury, or condition; and
2. it is not reasonable given the circumstances to obtain services through the Health Plan.

13.15 "Emergency Services"

Covered inpatient and outpatient services that are:

1. rendered by a Provider qualified to provide Emergency Services; and
2. necessary to evaluate or stabilize an Emergency Medical Condition.

13.16 "Enrollment Form"

The application for enrollment in the Health Plan.

13.17 "Experimental or Investigational"

A service, supply, equipment, drug or procedure is deemed experimental or investigational if one or more of the following conditions are met:

1. Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug for which Prior Authorization is requested that is proposed for off-label use;
2. Any service, supply, equipment, drug or procedure that is subject to the Medical Review Department review and/or approval;
3. Any service, supply, equipment, drug or procedure that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations;
4. Any service, supply, equipment, drug or procedure that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

13.18 "Formulary"

A listing of prescription drugs approved by the Health Plan for Coverage under the Agreement. These are dispensed through a pharmacy to Members. This list is subject to periodic review and change by the Health Plan. The Formulary is available for review in Participating Provider offices or by contacting the Customer Services Department, or by accessing our website at www.chcnebraska.com.

13.19 "Group"

An organization or firm contracting with the Health Plan to arrange health care services for Subscribers and their Dependents through which eligible Subscribers and Dependents become entitled to the Covered Services described herein.

13.20 "Group Master Contract"

The agreement between the Group and Us that states the agreed upon contractual rights and obligations of the Health Plan, the Group, and Members, and that describes the costs, procedures, Covered Services, conditions, limitations, exclusions, and other obligations afforded to Members.

13.21 "Group Effective Date"

The date that is specified in the Group Contract as the effective date of the Agreement.

13.22 "Group Enrollment Period"

Shall mean a period of time occurring at least once annually during which time any eligible employee may enroll with the Health Plan for Coverage under this Evidence of Coverage.

13.23 "Health Maintenance Network Coverage"

Covered Services provided to Members by Participating Providers in accordance with the terms and conditions of this Group Membership Agreement. These Covered Services must be performed by the Member's Participating Physician and, if required under the Schedule of

Benefits, authorized for coverage by Us prior to the Covered Services being obtained.

13.24 "Health Plan"

Coventry Health Care of Nebraska, Inc. (the Health Plan).

13.25 "Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing Health Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

13.26 "Infertility"

Infertility means the inability of a woman to conceive a pregnancy after six months of unprotected intercourse or the inability of a woman to carry a pregnancy to live birth.

13.27 "Late Enrollees"

Shall mean individuals who fail to enroll with the Health Plan for coverage under the Agreement during the required thirty-one (31) day period when they first become eligible for coverage. This term does not include Special Enrollees.

13.28 "Medical Director"

The Physician specified by Us as the Medical Director or other Health Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

13.29 "Medically Necessary"

Medically Necessary means those services, supplies, equipment and facilities charges that: are not expressly excluded under the Agreement and determined by Us to be:

(i) Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks*;*

(ii) Necessary to meet Your health, improve physiological function and required for a reason other than improving appearance;

(iii) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;

(iv) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the

services, supplies, equipment or facilities for which coverage is requested;

(v) Consistent with the diagnosis of the condition at issue;

(vi) Required for reasons other than Your comfort or the comfort and convenience of Your physician; and

(vii) Not Experimental or Investigational as determined by Us under our Experimental Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from our Member Services Department.)

13.30 "Member"

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for coverage under the Agreement in accordance with its terms and conditions.

13.31 "Member Effective Date"

The date entered on Our records as the date when coverage for a Member under the Agreement begins in accordance with the terms of the Agreement, which coverage shall begin at 12:01 a.m. on such date.

13.32 "Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Us to provide health services to Members.

13.33 "Out-of-Network Coverage"

Covered Services provided to Members by a Non-Participating Provider of the Member's choice. These Covered Services may still require Pre-Authorization. Consult Your Schedule of Benefits or contact Our Customer Service Department if you have a question as to whether Pre-Authorization is required.

13.34 "Out-of-Network Rate"

The amount We pay for Covered Services rendered by Non-Participating Providers under the Out-of Network Coverage option. A description of the rate is set forth in Section 1.2.

13.35 "Participating Provider"

A Provider who has entered into a direct or indirect written agreement with Us to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to You in connection the Agreement. The participation status of Providers may change from time to time.

13.36 "Provider/Provider Network"

A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

13.37 "Physician"

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the jurisdiction in which treatment is received.

13.38 "Qualified Medical Child Support Order"

Shall mean an order determined by Us to satisfy the requirements of section 609(a) of ERISA (29 USC § 1169 (a)).

13.39 "Retiree"

Shall mean a former employee of the Group who meets the Group's definition of retired employees to whom the Group offers coverage under this Evidence of Coverage. Not all retired persons qualify as Retires under this agreement.

13.40 "Service Area"

The geographic area served by the Health Plan as approved by the States of Nebraska and Iowa and shown on the Service Area description in this Evidence of Coverage. The Health Plan's Service Area is subject to change.

13.41 "Special Enrollment Period"

The period set forth in Section 2.6 of this Evidence of Coverage.

13.42 "Specialty Care Physician/Specialist"

A physician who provides medical services to Members within the range of a medical specialty.

13.43 "Subscriber"

The eligible employee or Retiree who has elected the Health Plan coverage for himself and any eligible Dependents through submission of an Enrollment Application and for whom, or on whose behalf, premiums have been received by Us.

13.44 "We/Us or Our"

Coventry Health Care of Nebraska, Inc.

13.45 "You/Your"

A Member covered under this Evidence of Coverage.

SECTION 14
GENERAL PROVISIONS

14.1 Applicability

The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

14.2 Choice of Law

The Agreement shall be administered under the laws of: (i) the State of Nebraska when the Agreement is issued pursuant to a health maintenance organization certificate of authority issued by the State of Nebraska; and (ii) the State of Iowa when the Agreement is issued pursuant to a health maintenance organization certificate of authority issued by the State of Iowa.

14.3 Clerical Error

Clerical error in record-keeping relating to the Coverage under the Agreement will not invalidate Coverage otherwise validly in force nor continue Coverage otherwise validly terminated.

14.4 Conflicts with Existing Laws

If any provision of the Agreement conflicts with state or federal law, that law shall pre-empt only that provision of the Agreement that is in conflict. If any provision of the Agreement conflicts with the requirements of federal or state law, the Agreement shall be administered in such a way as to comply with the requirements of the law, and will be deemed amended to conform with the law. The Agreement will be amended as required.

14.5 Entire Agreement

The Agreement shall constitute the entire agreement between the parties. All statements, in the absence of fraud, pertaining to coverage under the Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate coverage of a Member shall be used in any context to void the coverage, with respect to which such statement was made or to decrease Benefits hereunder after the coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

14.6 Events Beyond Control

If a natural disaster, riot, civil insurrection, epidemic or any similar event not within Our control results in Our being unable to provide Coverage under the Agreement, We are required to make a good-faith effort to provide Coverage, considering the impact

of the event. We will be liable to reimburse the expenses for Medically Necessary Covered Services under the Agreement, as prescribed by the Insurance Commissioner of Nebraska and Iowa.

14.7 Exhaustion of Administrative Remedies

Neither You nor a Group may bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in the Agreement have first been exhausted.

14.8 Nontransferable

No person other than You is entitled to receive health care service coverage or other benefits to be furnished by Us under the Agreement. Such right to health care service coverage or other benefits is not transferable.

14.9 Relationship Among Parties Affected by Agreement

The relationship between the Health Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Health Plan, nor is the Health Plan or any employee of the Health Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Group nor You is an agent or representative of the Health Plan, and neither shall be liable for any acts or omissions of the Health Plan for the performance of services under the Agreement.

14.10 Reservations and Alternatives

We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

14.11 Severability

In the event that any provision of the Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of the Agreement, which shall continue in full force and effect in accordance with its remaining terms.

14.12 Valid Amendment

No change in the Agreement shall be valid unless approved by an officer of the Health Plan, and evidenced by endorsement on this Evidence of Coverage and/or by amendment to the Agreement. Such amendment will be incorporated into this Evidence of Coverage when applicable.

14.13 Waiver

The failure of the Health Plan, the Group, or You to enforce any provision of the Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Agreement shall not be deemed or construed to be a waiver of such default.

SECTION 15
SERVICE AREA DESCRIPTION

The Service Area is comprised of the following counties:

In Nebraska: Antelope; Burt; Cass; Cuming; Dodge; Douglas; Fillmore; Johnson; Lancaster; Nemaha; Otoe; Pawnee; Sarpy; Saunders; Thurston; Washington; and Wayne.

In Iowa: Cass; Crawford; Fremont; Harrison; Mills; Monona; Montgomery; Page; and Pottawattamie.

SECTION 16

IMPORTANT ADDRESSES AND PHONE NUMBERS

To submit a medical claim, general correspondence, questions regarding claims processing, or to file a written complaint: P.O. Box 7705London, KY 40742-7705To contact Customer Service to verify eligibility and /or benefits, to check status of a medical claim, or to file a verbal complaint:

800-288-3343

For Pre-Certification:

800-471-0240 ext. 6352

For urgent care outside the service area, call us or (866) 676-7427 to locate a PHCS provider.

To submit a mental health claim, general correspondence, questions regarding claims processing, or to file a written complaint or appeal:

APS HealthCare, Inc.

P.O. Box 1246

Rockville, Maryland 20849-1246

To contact Customer Service to verify mental health benefits, to check status of a mental health claim, or to file a verbal complaint:

800-752-7242

To file a pharmacy claim:

CareMark

P.O. Box 659574

San Antonio, Texas 78265-9574

800-378-7040

To file a Grievance regarding a medical claim:

P.O. Box 541210

Omaha, NE 68154-9210

800-471-0240

Please visit us at www.CHCNebraska.com